

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009274

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1342

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

FILED FEB 19 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 2013 Palm Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE First C. Middle RICHARDSON Last		4. DATE OF DEATH Month 2 Day 5 Year 63	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Unknown		11b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv no		16. SOCIAL SECURITY NO. 4200	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspirator of Vomitus altered areas of @ lower + upper lobe Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chilresschulhe Heart Disease DUE TO (c) Chilresschulhe Heart Disease		17. INFORMANT Address Dora Walker 2013 Palm Ave.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION 1515 LAFAYETTE AVE.	
21. I attended the deceased from 2 1 63 to 2 5 63 and last saw her alive on 2 5 63		22a. SIGNATURE (Do not print name) Thomas J. Richardson	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 2 5 63	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2-8-1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Buchholz Mortuary		25. DATE RECD. BY LOCAL REG. FEB 7 1963	
26. REGISTRAR'S SIGNATURE Roan Smith, M.D.			

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RIZON
USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph E. Linder

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.